

NATIONAL INSTITUTE OF MENTAL HEALTH RESEARCH PROJECT

REPORT OF THE LEWISHAM DAY CENTRE FOR REFUGEES AND ASYLUM SEEKERS SOUTH LONDON

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We would express our heart felt gratitude to the South London and Maudsley NHS Trust for the support provided during the application process, the steering group process and during the research and with comments to the final report. Thanks for especially to Jane Hannon and Juney Mohammad of the Lewisham Adult Mental Health division of the Trust for their support and input throughout this project

Many thanks also go to organisations and individuals who formed the initial consultation process that eventually led to the recruitment of researchers to reflect the diversity of the BME groups sampled and included in the research process. Their contribution makes this report a wide reflection the knowledge and problems relating to mental health and access to services affecting refugees and asylum seekers.

The list of organisations and individuals include: Oasis Resource Centre, FRANCOEAST, Agenda For Community Development who all worked under the Lewisham Day Centre for Refugees and Asylum Seekers.

Our thanks go to our many volunteers who have travelled all over Lewisham and surrounding boroughs to collect data and for their good quality work, but also our members for their willingness to provide us with the needed information.

We would like to give special thanks to the communities of Refugees and Asylum Seekers, who despite their usual problems of isolation, over consultation, were able to come to our focus group meetings and discussions. The research team was able to fill in more questionnaires during such meetings.

Thank you all.

Brief profile of researchers:

Our researchers come from a wide background and this reflects the range of asylum seeking and refugee communities living or working the London Borough of Lewisham. Some of the volunteers for the project can from partnership organisations managing the Day Centre.

David Oola (Ugandan): is a volunteer from the Agenda For Community Development, which is a partner organization for the Day Centre. I was nominated to lead this project. I am a graduate in Development Policy and Planning, and now I hold a certificate in Community Research through participation in this research.

I have extensive experience of community work and I am involved in numerous projects in community development. My involvement with this Research Project has enabled me to gain a greater insight into mental health issues amongst refugees and asylum seekers.

Jean Omer Mpeho (Congo Brazaville): is the Project Manager for FRANCOEAST (a partner organization in the Day Centre Partnership). I was nominated to be assistant lead person for this project. I am a graduate in community work and I volunteered as a researcher.

I work a lot with community groups and I also advice on immigration and I do translation work in French, Kikongo and English. At FRACOEAST I am responsible for developing education, employment, training, recreation/sport and advice services for Francophone Africans, and I am responsible for co-coordinating a range of cultural and educational activities. I learned a lot about mental health as part of this project. I was involved in developing questionnaires and interviewing for this project.

Bafeka Ndeka (Democratic Republic of Congo). I am the chairperson for Oasis Resource Centre, a partner organisation in the Day Centre partnership. I am a BA (Honours) Degree holder. I am currently involved in voluntary youth and community work and I help with translation work with migration lawyers.

I got involved in this project to increase my level of mental health awareness and to help with this research. From the project I have realised that there is a need for more resources for mental health work amongst refuges and asylum seekers. I was involved in developing questionnaires and interviewing for this project.

Ruquiya Ahmed (Somalia). I am a volunteer at the Pepys Community Forum. I am an experienced community and outreach worker. I have been involved in many drugs education projects among the Somali and I was attracted to a project like this catering for refugees and asylum seekers.

The role I have in this project is a volunteer was to collect and do interviews for the project among the Somali women. This project has given me experience of working within my community. I was involved in developing questionnaires and interviewing for this project.

Zahra Cabaad (Somalia). I am community worker at the Pepy's Community Forum. I deal with caseload work among BME groups. My role in this research was to administer questionnaires and focus group discussions among Somali women. I was involved in developing questionnaires and interviewing for this project.

Sayed Ahmad (Jordan): I am a barber by trade. I became interested in this project because I see many of my community members affected by lack services. I thought

joining this project was going to help raise awareness about lack mental health services amongst refugees and asylum seekers. My role in this research was to administer questionnaires and focus group discussions among Arabic speaking groups. I was involved in developing questionnaires and interviewing for this project.

Mohamed Aljaber (Ahwazi, Iran). I am a traditional musician by trade and I am a volunteer with the Ahwazi Community Association. My role in this research was to administer questionnaires and focus group discussions among Ahwazi, Farsi and Arabic speakers. I was involved in developing questionnaires and interviewing for this project.

Felix Mboko (Democratic Republic of Congo). I am now disabled due to a stroke. I got involved in this project to get involved in community work because I am house bound most of the time. My role in this research was to assist in running focus group discussions among French and Congolese speakers. I was involved in developing questionnaires and interviewing for this project.

George Eleko (Democratic Republic of Congo). I am a graduate of Civil Engineering and I am a volunteer at the Day Centre, where I help with day to day running of the Centre. My role in this research was to administer questionnaires and focus group discussions among French and Congolese speakers. I was involved in developing questionnaires and interviewing for this project.

Introduction:

This report is in part fulfilment of the Mental Health survey among refugees and asylum seekers living in the London Borough of Lewisham. The research survey was done by the Lewisham Day Centre for Refugees and Asylum Seekers. The remit of the project was to research into the mental health needs of Refugees and Asylum Seekers in the London Borough of Lewisham.

The survey was prompted by the increasing needs health uptakes by refugees and asylum seekers and about their difficulties in accessing health services.

The research was commissioned by the University of Central Lancashire funded by the National Institute for Mental Health in England and supported and managed by the University of Central Lancashire in July 2005 and was completed in February 2006 and involved 230 refugees and asylum seekers being interviewed with regard with their access to mental health services.

The parameters for this particular research were set against the extent to which availability of services meet the Building blocks as identified in the Delivering Race Equality's programme of change is founded on three building blocks;

- **More appropriate and responsive services** - achieved through action to develop organisations and the workforce, to improve clinical services and to improve services for specific groups, such as older people, asylum seekers and refugees, and children.
- **Community engagement** - delivered through healthier communities and by action to engage communities in planning services, supported by 500 new Community Development Workers.
- **Better information** - from improved monitoring of ethnicity, better dissemination of information and good practice, and by improving knowledge about effective services. This includes a new yearly census of ethnicity of mental health patients. (Department of Health. (2005) "Delivering Race Equality in Mental Health)

Aim of the research:

The aim of the research was to examine the mental health needs of refugees and asylum seekers. The Objectives are:

- To identify barriers to the accessibility of mental services for refugees and asylum seekers and make recommendations to improve services.
- To identify barriers to mental health services experienced by this specific target group
- To identify ways in which these barriers might be overcome/improved
- To identify examples of good practice and explore other ways of making provision more appropriate to the needs of refugees and asylum seekers
- To inform services providers, policy makers and other agencies on the level of accessibility of mental health services for refugees and asylum seekers.

Executive Summary

In January 2005, the Department of Health (DOH) and National Institute for Mental Health England (NIMHE) published the “Delivering Race Equality in Mental Health; An Action Plan for reforming the delivery of mental health services and the Government’s Response to the Independent Inquiry into the Death of David Bennett.

Delivering Race Equality (DRE) in Mental Health care is a five year action plan for achieving equality and tackling discrimination in mental health services in England. It outlines also the Government response to the recommendations made by the inquiry into the death of David Bennett for all people of Black and minority ethnic status, including those of Irish or Mediterranean origin and east European migrants. The action plan has the potential to improve the care for any group affected by disparity in health and healthcare, including Black and minority ethnic older people, children and adolescents, refugees and asylum seekers.

Equality in mental health services is not a new requirement. Many of the actions described in *DRE* have their roots in existing legislation, guidance or initiatives. Many are to be taken at national level, by the Government or other bodies. *DRE* pulls them all together, sets them in a mental health context, and adds the key, focused activity that is needed now to ensure rapid delivery.

In the national context, the Delivering Race Equality framework supports the implementation of the 10 point race equality action plan for the National Health Service published in February 2004. As a document Delivering Race Equality is basically an action plan outlining key recommendations of how the National Institute of Mental Health in England (NIMHE) intends to meet the mental health needs of the Black and Minority Ethnic groups in England.

The document clearly identifies the regional role of NIMHE, Race Equality Leads, roles of Local Implementation Teams (LITs), roles of Community health Team and Mental Health Trusts in delivering race equality in mental health.

Actions for Delivering Race Equality are based on three building blocks:

Block ONE specifies that there should be improve clinical care of all BME groups by:

- Developing organisations so that they offer high quality, Non-discriminatory and recovery-oriented healthcare
- Developing a work force that can deliver equitable care to BME populations
- Improving clinical services for BME populations and
- Improving services for specific populations, including older people, asylum seekers and refugees, children and young people

Block TWO puts emphasis on Engaging Communities. This block lists the actions needed (inside and outside mental health services) to give BME communities genuine opportunities to influence mental health policy and provision, and to promote mental health and recovery, include:

- Help build healthier communities, and to
- Engage communities, build capacity, deliver services and facilitate change in local mental health services

Block THREE lists actions to ensure the provision of Better Information. This is to make sure that there is improved or better information on service use and needs, and knowledge of recovery-enhancing environments and approaches. The block calls for action to:

- Improve the monitoring of ethnicity and mental health service use
- Improve the analysis and dissemination of information
- And to improve the knowledge available on effective services and evaluate the impact this action

The Lewisham Day Centre used community consultation focus group discussions and face to face individual questionnaire interviews with **230** refugees and asylum seekers to collect data. A focus group discussion was also held with mental health services from South London And Maudsley National Health Trust for Mental health.

Summary of Recommendations

Information provisions

- Produce a user-friendly leaflet about mental health services in the most spoken community language on mental health services available and procedures for accessing them and on specific issues for refugees and asylum seekers.
- A list of definitions of mental illnesses need to be readily available so that those affected can self assess or help other friends or family members if they see them experiences symptoms of mental illnesses.
- Update and supply these information materials continuously and as long as refugees and asylum seekers continue to come to the UK and as long as they are needed.
- Distribute these information materials to as many refugees and asylum seekers and users of refugee community organisations.
- Monitor and facilitate the dissemination of these information materials.
- Link with more relevant agencies and other community organisations in order to share information and experience as to how to better tackle mental health issues within refugees and asylum seekers communities.

Advocacy and interpreting

- Encourage community advocates and interpreters to use community languages.
- Collaborate with statutory departments and other service providers to

facilitate interpreting and advocacy needs of services users, for example with social services.

Liaising with service providers and training for the community

- Conduct seminars on a wide range of mental health issues as they affect refugees and asylum seekers.
- Provide regular mental health awareness training to community workers and volunteers

Resources

- Make more resources available for asylum seekers and refugees in order to provide more services in advocacy / interpreting and cultural counselling as well as information provision for refugees and asylum seekers.
- Make more resources available to mental health service providers and agencies that have clients such as refugees and asylum seekers who do not speak English.
- Helping the centres providing services become more efficient and more responsive to the needs of refugees and asylum seekers.
- Helping the Centres with the necessary resources to inform refugees and asylum seekers about mental health issues

Why our involvement in the project

The Lewisham Day Centre for Refugees and Asylum Seekers is only one year old and is a culmination of a two year consultation process amongst 14 refugee led organisations. Because we are the only such day centre for refugees and asylum seekers in the London Borough of Lewisham, we are up to setting up a “Needs Led” project that evolves with the needs of our users and policies that affect them.

We got involved in this research because it was one of the ways through which we could make known huge gaps in services for refugees and asylum seekers since the introduction of the new Nationality, Immigration and Asylum Act 2000.

From the view point of the Lewisham Day Centre for Refugees and asylum seekers, we are yet to see how such national initiative can benefit the hardest to reach. Many reports confirm the fact that people with mental illness are among the most excluded groups in society. Among our service users (refugees and asylum seekers), depression, anxiety, phobias affects lots of people and yet they cannot even get onto the ladder to start being assessed for treatment.

In the Lewisham Primary Care Trust area, mental health services are in the process of being streamlined and a range of services are being rolled out. And for BME communities, the systems for delivering mental health or consulting or monitoring BME usage of mental health services is unnecessarily complex and difficult to comprehend let alone being involved in any related processes.

(Lambeth, Southwark and Lewisham Primary Care Trust website: www.lsl.nhs.uk).

“Delivering Race Equality in Mental Health Care” is written as an action plan, but knowing how many changes were introduced by the Government on Health services, it is going to take a lot of resources and keen work for refugees and asylum seekers to benefit from the Action Plan. Local service hubs need to work with various BME organisations to stream line how Delivering Race Equality will if ever have impact for the Hard-to-reach groups who are always outside any decision making loops.

Through this project, we wish to find out effective ways and means through which the mental health needs of refugees and asylum seekers living in the London Borough of Lewisham can be met as part fulfilment of priorities identified in the reports mentioned. As a new centre, we intend to provide needs led services as well as work with local PRIMARY CARE TRUSTS and mental health teams to:

- Carry out a needs assessment on how best to engage or provide services accessible to BME groups, Refugees and Asylum Seekers
- Find out what the professional service providers think are key problems of accessing services for BME groups, Refugees and Asylum Seekers
- Find views of both mental health providers and users on service provision
- Find out what it takes to develop more appropriate and responsive services for the black and minority ethnic refugees and asylum seekers by

- statutory service providers
- Develop a mental health workforce capable of working with and treating different communities
- Better engagement of black and minority ethnic refugee and asylum seeker groups in shaping mental health services and supporting innovative, community informed services
- Work towards improving collection and more effective use of information to assess and target service developments for the hard to reach communities. **(Department of Health. (2005) “Delivering Race Equality in Mental Health)**

The Lewisham Day Centre for Refugees And Asylum Seekers

The Day Centre is a service run and managed by a partnership of refugee led organisations, refugees, asylum seekers and volunteers. This approach to work was agreed upon because refugees and asylum seekers live in a constantly changing environment, we provide needs assessments to update the needs as well as keep track of our beneficiaries. Through the centre, we are currently providing the following services:

- Health promotion, but specifically mitigating mental health problems
- Health promotion, prevention of sexually transmitted diseases
- Promoting Healthy living through cookery demonstrations
- Networking with possible service providers
- Opportunities for sign posting to other sources of help
- Providing a social contact for beneficiaries to interact
- Interpretation across common languages used by our service users: French, Farsi, Arabic, Somali to English and vice versa.

The activities are managed by a volunteer Centre Coordinator. Refugee led organisations who form the centre partnership provide sessional workers and volunteers. Refugees and asylum seekers themselves are also involved in the centre. They provide cookery demonstrations, play music, dance and drama and help with setting up and arranging the centre.

The Refugee Health Team provides specific and confidential one to one surgeries and there are always a number of health promotion kits and leaflets on display.

Profile of the project Area

London Borough of Lewisham 2001 Census data has the following statistics: 246,200 people: 68.2% White; 12.1% Black Caribbean; 7.2% Black African; 4.1 Black Other.

Black groups make 23.4% with: 1.2 Indian; 0.6 Pakistani; 0.4 Bangladeshi; 1.2 Chinese; 1.6 Other Asian. If added, the Asian groups make 5%. Above statistics misses out refugees and asylum seekers. **(Census 2001).**

There are also a number of cross-borough reports that look at different health issues affecting refugees in the three boroughs of Lewisham, Southwark and Lambeth. Most recently, the Refugee Health Team has carried out a needs assessment among young refugee community organisations on a number of issues including mental health needs **(Rojas and Webster, 2000)**.

A mapping exercise was been undertaken by the Refugee Outreach team to map out where many asylum seekers are accommodated and availability of services that they can access.

Factors influencing uptake of primary health care services were examined. It found that for many refugees, other issues take priority over health, such as housing, immigration, benefits and unemployment. Some refugees interviewed also expressed their concern over confidentiality and who to trust with their personal problems.

Lack of information and communication barriers were also key barriers, with 52% of respondents not understanding English. They attributed their poor health to uncertainty about the future and being separated from family and friends and 45% reported feeling depressed. This study also presents the providers perspective and consulted GPs in Brixton, half of whom did not know whether refugees or asylum seekers were eligible for free NHS treatment. Problems of getting interpreters were also mentioned.

In 1998, a study of refugee and asylum seekers in Lambeth was undertaken **(Platt-Macdonald & Smalling, 1998)**, with part of the study focussed on the health professionals' knowledge of refugees and service delivery. The report also examined client demography and reported that there are 16 different languages spoken amongst refugees from 33 countries, living in the PRIMARY CARE TRUSTS zone. The study highlighted that many health professionals felt that they had insufficient knowledge in relation to the health needs of refugees and asylum seekers and again highlighted the need for better interpreting services.

Lack of information, resources and unclear avenues for providing services were identified by health professionals as being a major barrier to them carrying out their work with asylum seekers and refugees. It was found to be time consuming trying to find out the relevant information and making referrals.

The lack of knowledge among professionals highlighted in this report was taken up by the Refugee Outreach Team who went on to develop and deliver a training programme for health practitioners, particularly GPs and health visitors. Other recommendations included joint working, better links with community groups, the need to develop a trust wide strategy and employing members of refugee communities to interpret and act as health advocates.

Concern surrounding the placement of a large number of asylum seekers in the London Park Hotel prompted a study on the mental health needs of Kosovans resident in this hotel **(Dean, 1999)**. The report showed that this hotel accommodates 700 asylum seekers, the majority of whom are not on benefits, but receive subsistence from social services. At the time of the report, the

majority of residents were single men between the ages of 16 and

Health Questionnaires were used to detect mental health disorders and it was found that almost half of those surveyed scored above the threshold of 4. The report discusses the factors that may have contributed to this, including being separated from family, interrupted education in Kosovo and having spent most of their life in a country experiencing violent civil war. Dean points to loneliness and boredom as being a main problem for this group and recommends sporting activities to be organised and 'some form of social support.'

Putting the health as well as mental health needs of refugees and asylum seekers is the reason why we intend to carry out a needs assessment that will link identified needs with clear working practices that will enable health and mental health professionals and voluntary/ community organisations to work together to achieve the local Primary Care Trust's health objectives.

The Project:

The project aim is to assess the mental health need of refugees and asylum seekers as well as to identify barriers to the accessibility of mental health services for refugees and asylum seekers in Lewisham, and make recommendations to the Lewisham Day Centre and to Service provider's agencies in order to improve access.

Objectives:

- To assess the mental health needs of refugees and asylum seekers
- To identify barriers to mental health services available in Lewisham
- To identify ways in which these barrier might be overcome
- To inform the Social Services and Mental Health Services providers and other agencies about the levels of accessibility for mental health services to refugees and asylum seekers.

Methodology:

The Lewisham Day Centre used community consultation focus group discussions and face to face individual questionnaire interviews with 230 refugees and asylum seekers to collect data. A focus group discussion was also held with mental health services from South London And Maudsley National Health Trust for Mental health. We hope that the outcomes of this project will enable services provider thought London to find more appropriate ways of providing health services to our target group.

For the last 2-3 years, the difficulties faced by refugees and asylum seekers who sought the Lewisham Day Centre' services, indicated the need of clearer examination of the problems, opportunities and potentials for effective and efficient access to services for the Lewisham Day Centre's users, particularly with regard to mental health.

The research project passed through a number of different phases that included project launch, community consultations, qualitative research, questionnaire, translation to community languages, piloting quantitative research, data analysis to report writing.

Project launch:

The Project was launched in August 2005 at a meeting with refugees and asylum seekers. The aims and objectives were presented to the audience. Discussions were held on how best the project could be carried out. And some agreements were made.

Community consultation:

Following the initial meeting, the Lewisham Day Centre appointed a sessional research worker and eleven volunteers from various communities. Volunteers were involved in continued consulting with other refugees and asylum seekers who were unable to attend the initial meeting. This was to gather representative information.

Community groups' discussions meetings were also organised in various community languages to make sure every refugee and asylum seeker who participated understood the project and could give their views.

Data collection:

A combination of qualitative and quantitative methods was used in the research in order to gather more information.

Qualitative research:

This involved group discussions to collect qualitative data. The research officer prepared topic for discussions on issues related to refugees and asylum seekers with regard to service accessibility. Participants were also given the opportunity to respond, to modify or add topics to be discussed. The appropriate community languages were used for the discussions. The findings of the qualitative data helped to decide on issues to be included in the quantitative research (questionnaire).

Quantitative research:

Quantitative research was undertaken to quantify the problems and concerns expressed during consultation and focus group discussions. This included questionnaire/interview covering all issues related to the difficulties experienced by refugees and asylum seekers, and questions were placed under each paragraph accordingly.

Sampling techniques:

A combination of quota and snowballing sampling techniques were used to collect data.

Quota sampling:

According to the Refugee Health Team, the target population of refugees and asylum seekers in Lewisham was of around 1800-2000 at the time of the project's launch. The management team of the Lewisham Day Centre decided to interview a minimum of 300 refugees and asylum seekers. However, we finally interviewed 234 refugees and asylum seekers. Factors such as gender, age, marital status, accommodation, education, employment, immigration status and length of stay in the UK were taken into account while deciding on the size of the sample.

Snow balling:

Interviewers asked respondents if they knew other potential interviewees who would be willing to be interviewed. Interviewers were also encouraged to try to reach other refugees and asylum seekers who did not yet use the services of the Lewisham Day Centre.

Data analysis:

Quantitative data was analysed utilising the standard statistical package for social sciences.

Difficulties encountered during the research:

1. Officers and volunteers involved in the research encountered some hurdles with this process. For example some people were a bit reluctant in giving some information. This was very demanding and time consuming. But we managed to reach a wide range of refugees and asylum seekers from various backgrounds even more than our expectations and this has constituted a representative sample. In addition the verbal translation of the questionnaire into specific community languages was also a difficult task.
2. We hope that this research will encourage mental health service providers to be more responsive to the mental health needs of refugees and asylum seekers and with this regard will support the work of the Lewisham Day Centre.
3. We also had problems with receiving funding for the project. The project ran to a near stand still between June to September because we did not know how and where to get specially the second instalment from.
4. Lastly, at the project brief, we were told the Race Equality office was going to be instrumental in this project and our work was of direct importance to ensuring that they gear-up to meeting Delivering Race Equality in mental

health targets. To date we do not know who our Race Equality Officer is.

5. The other serious problem we encountered was setting up the steering group. Getting officers from the Mental Health Trust, Race Equality Office and the researchers was difficult, especially getting dates for face to face meetings. After four meetings, we agreed on using an electronic steering group where we circulated and exchanged information by e-mail.

Project Evaluation

The project was evaluated through the Department of Mental Health Sciences of the Royal Free and University College of London. This involved an additional questionnaire designed by the Department of Mental Health Sciences, in which respondents were asked about their general well being since they arrived in the UK. The results of the evaluation process confirmed some of the majority of the findings identified through the research itself. It was particularly noted that although the very large of majority (78%) did not have any physical health problems, almost the same number reported that they experienced many forms of mental disturbances ranging from anxiety, depression, mood swings, etc and 11% reported to have suffered from nervous breakdown.

It was also noted that the main reason for these problems are linked to homelessness; the lack of money for social activities, to keep themselves tidy, to look after their home, when they have one; but also boredom. And 80% preferred the setting up of a community project that can be accessed easily.

At the end of the process, we asked respondents about what they thought of the process and a high percentage of respondents (93%) reported that they hoped the findings of the research and the evaluation would encourage services providers to make more resources available that would help to meet their needs.

Research Results (Facts and Figures):

This part presents the research/survey findings. Issues presented in tables were highlighted in discussions.

Demographic Information:

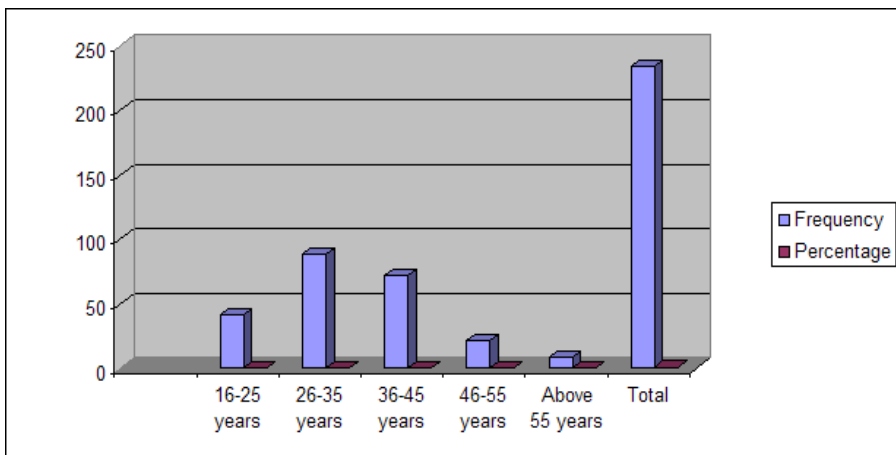
(Location, Gender, Age, Marital Status, Immigration's Status and religious orientations of respondents).

The total number of respondents interviewed was of 234 (153 males – 65 % and 81 females). Female respondents represented 35% and males 65%.

The sample distribution was as follow:

Table 1: Age distribution

Age	Frequency	Percentage
16-25	42	18%
26-35	89	38%
36-45	72	31%
46-55	22	9%
Above 55	9	4%
Total	234	100%



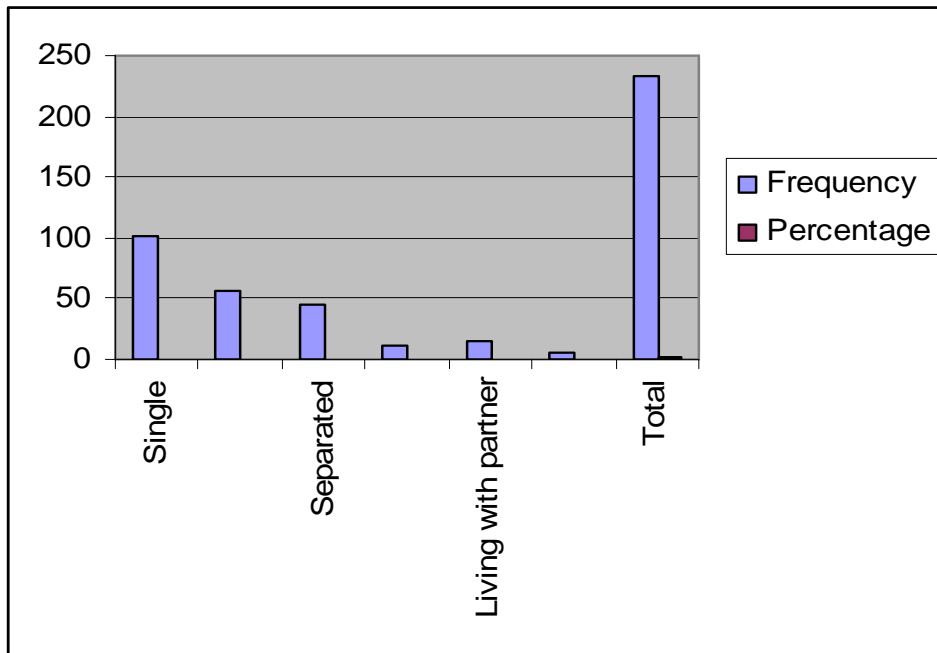
Marital status:

43% of the respondents were single. Some respondents were categorised as separated because they were not legally separated or divorced but did not live with their partners as a consequence or fleeing their countries for political or war reasons.

Table 2: Marital status distribution

Marital status	Frequency	Percentage
Single	101	43%
Married	56	24%
Separated	46	20%

Legally separated/divorced	11	5%
Living with partner	15	6%
Widowed	5	2%
Total	234	100%

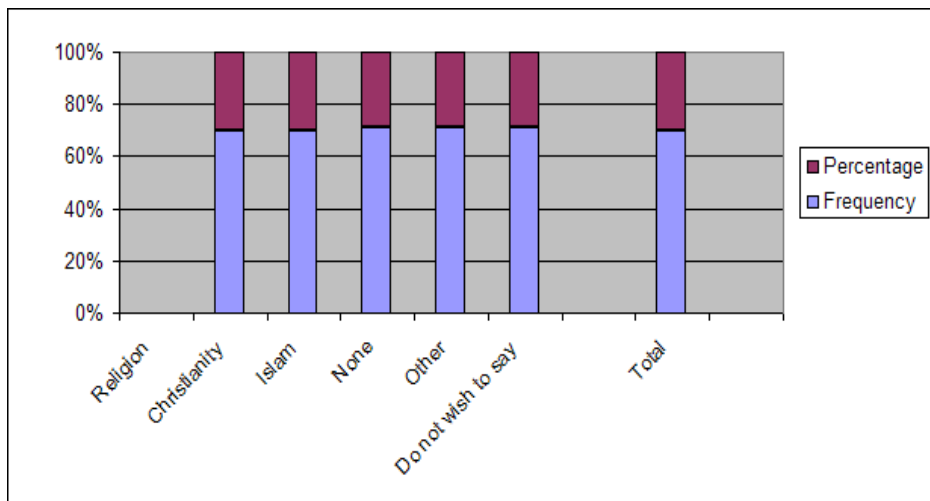


Religion information:

Respondents were from various religious denominations as described below. Very few were without religion

Table 3: Religions orientations distributions

Religion	Frequency	Percentage
Christianity	91	39
Islam	123	53
None	5	2
Other	10	4
Do not wish to say	5	2
Total	234	100



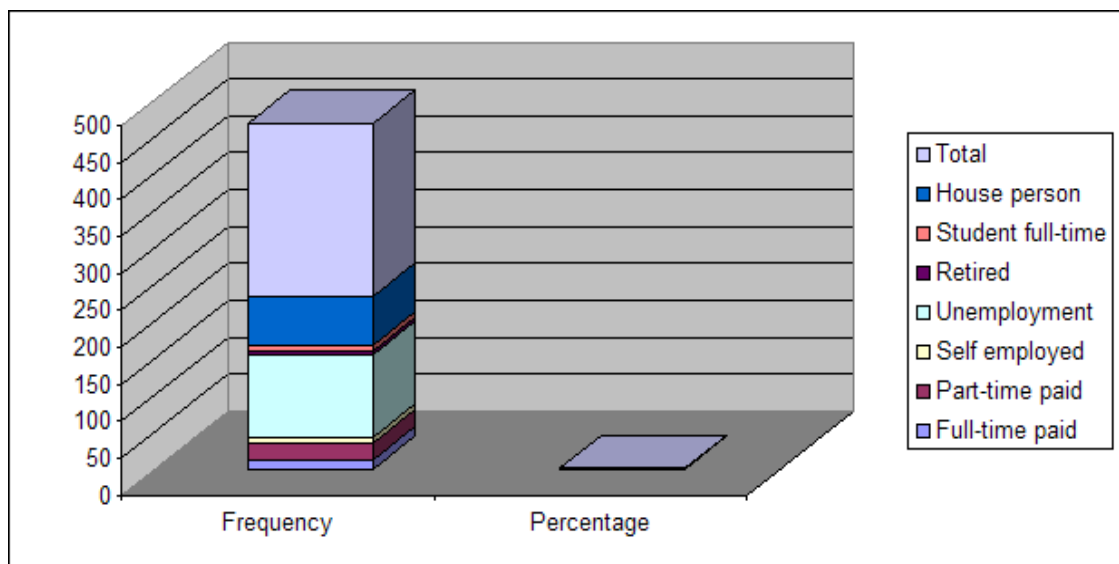
Education:

A percentage of respondents (12%) had at least a Baccaulaureate (equivalent of A Level). Most of them were men. A proportion of (25%) of interviewees had first and second degree and (8%) of respondents reported to have Bachelor Degrees while (7%) of respondents reported to have a post graduated degree or certificate. A proportion of 7% of respondents reported to have no formal education.

Table 5: Education level distribution

Level of education	Frequency	Percentage
No formal education	17	7%
A level	29	12%
Diploma	17	7%
Certificate	13	5%
Degree	19	8%
O level	59	25%
Post graduate	16	7%
Primary	57	24%
Total	234	100%

Refugees and Asylum Seekers who were interviewed reported to have a quite high level of education or qualification this demonstrates indeed that given more to services and opportunities, they were able to contribute not only to the development of their community but also the British society.

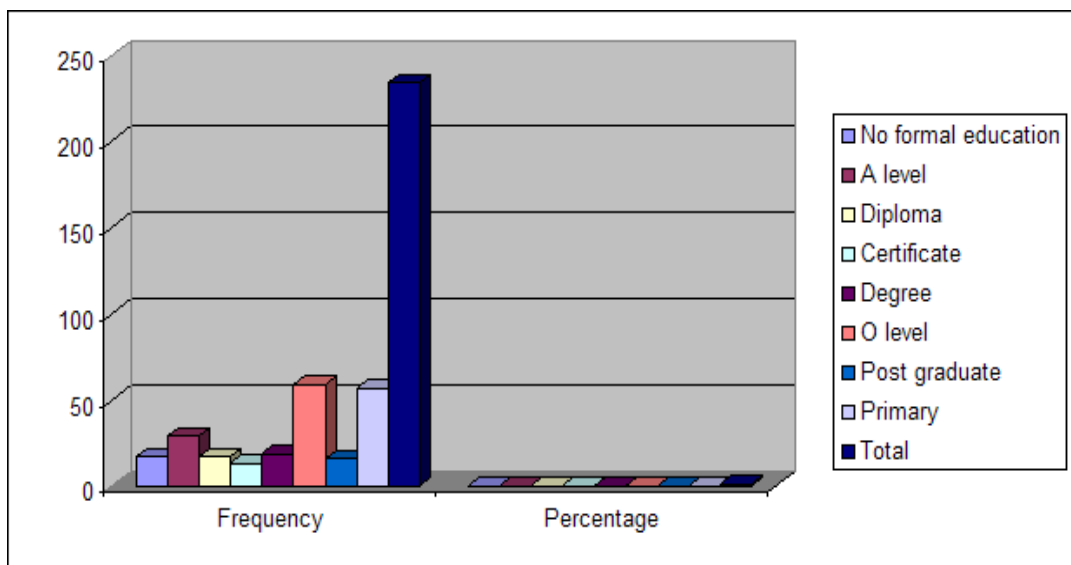


Employment status:

The Lewisham Day Centre's member's unemployment rate is 48%.

Table 6: Employment distribution

Employment	Frequency	Percentage
Self employed	6	2%
Unemployment	112	48%
Retired	6	2%
Student full-time	8	3%
House person	65	28%
Total	234	100%



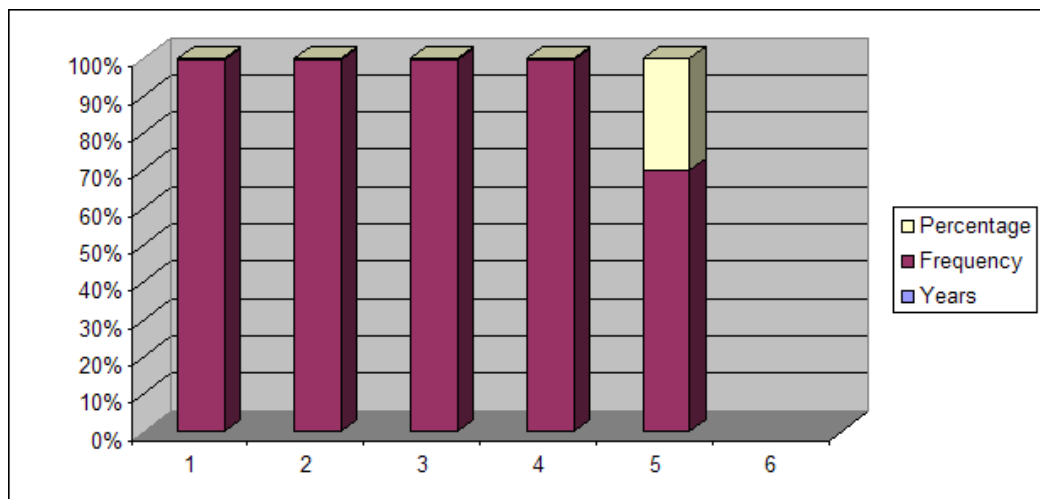
Although most of respondents were young adults and very active, a great number of them were unemployed. But this can be attributed to the English barrier. Almost all single respondents without children reported that they were not receiving any benefits whatsoever. But it was reported that unfortunately most of them got into courses of very low level in comparison to what they have already got.

Length of stay in UK

Interviewees included refugees and asylum seekers who arrived in the UK from six months up to more three five years. It seemed that the longer respondents stayed in the UK the more their English improved. The length of respondents in the UK is presented as follow:

Table 8: Length of stay in the UK

Years	Frequency	Percentage
< 1 year	75	32%
1-3 years	93	40%
3-5 years	52	22%
> 5 years	14	6%
Total	234	100



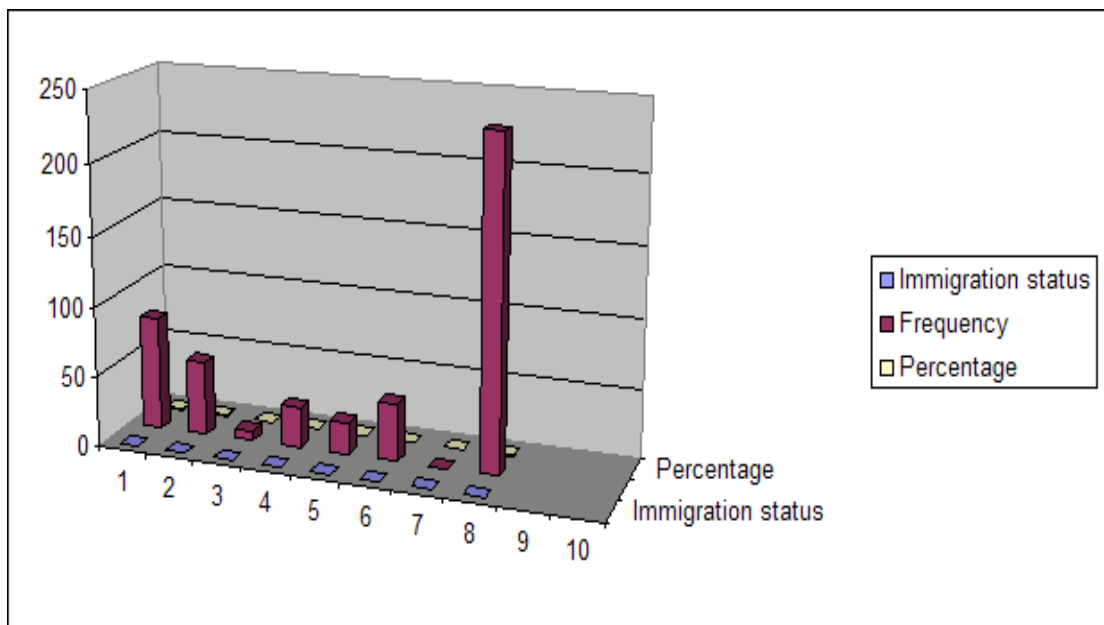
Immigration status

A high percentage (23%) of respondents reported to have their case undecided by the Home office. A percentage of 35 percent of respondents reported that

their application for asylum were rejected and had lodged an appeal to which they had not received a response yet. This causes a great discomfort as people live in the uncertainty of their immigration status. Only a very low percentage (20%) of respondents reported to have a permanent residency in the form of indefinite leave to remain, and refugee status combined. The immigration status is distributed as follow:

Table 9: Immigration status distribution

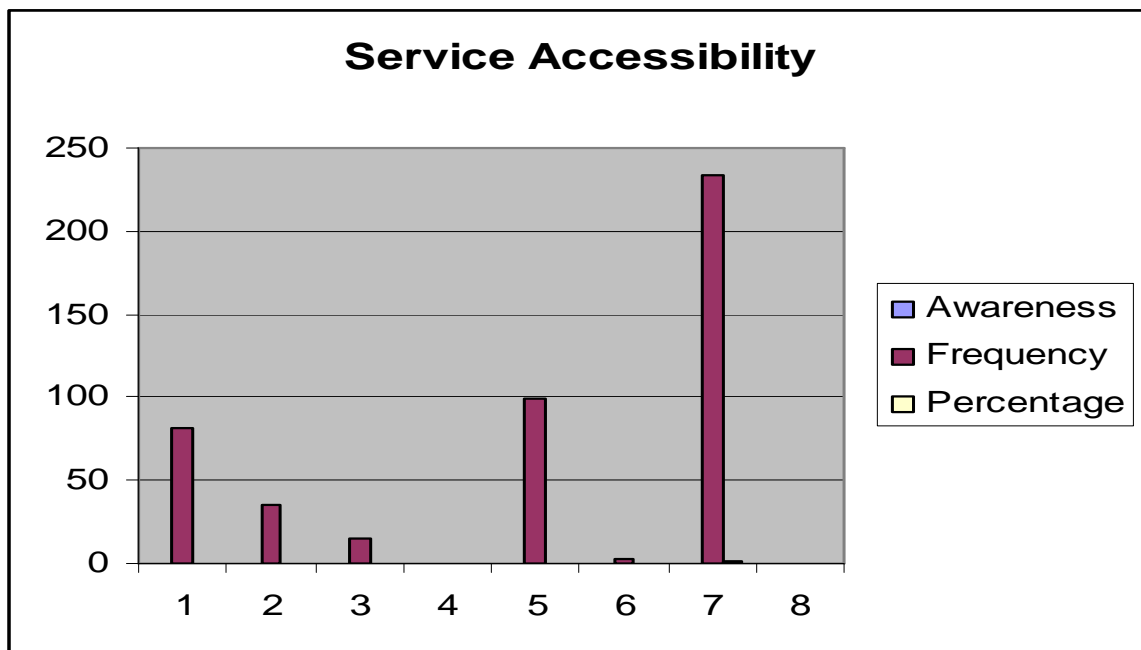
Immigration status	Frequency	Percentage
Refused application	81	35%
Waiting to hear	53	23%
Refugee status	7	3%
Leave to remain	29	12%
Exceptional leave	23	10%
Indefinite leave	41	17%



SERVICES ACCESSIBILITY

Respondents were asked about their awareness as to services that might be available to them and all other opportunities they could be entitled to in areas such as: Education, Training, Employment, Health (surgeries), Social Services, DSS, Dentists etc... The following table describes respondents' awareness about these services.

Awareness	Frequency	Percentage
About aware	81	35%
Aware	36	15%
Very aware	15	6%
Not aware	99	42%
Other	3	1%
Total	234	100%



Respondents were also asked about their accessibility to services for the last 3-5 years. Here are the frequency and percentage of how they had accessed these services.

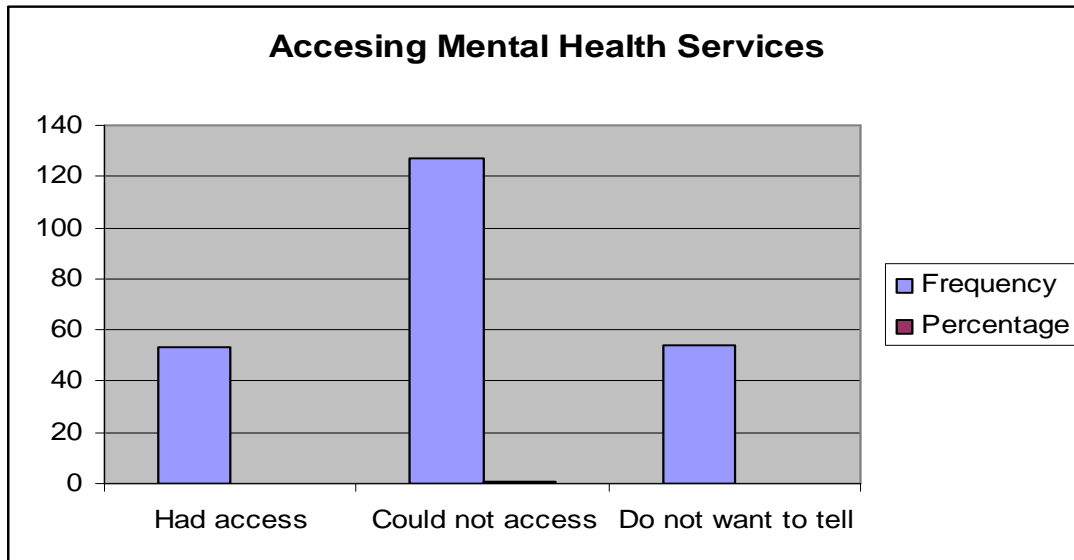
Accessing Services

The majority of respondents (42%) reported that they were not aware of services that were available to them. Most of respondents said that it was due to language problems defined as their inability to communicate or to read leaflets or all other forms of services publicity. A percentage of 35% reported that, although they were about aware of services, they did not know the location of service providers in their area, and were unable to find out by themselves.

A small proportion of 32% thought that seeking for services might affect their application for asylum. A small proportion (1%) reported that they gave up seeking services because of the way they were treated by service provider officers. Other respondents reported that some services providers agencies refused to offer their services to people who did not speak English, unless they could bring their own interpreters. Some respondents reported that they were mistreated by the first service provider agencies they approached; consequently they did not want to approach any other service provider agency, although the needs were still unresolved.

The following table indicates some reasons why some respondents did not have access to services:

Access	Frequency	Percentage
Had access	53	23%
Could not access	127	54%
Do not want to tell	54	23%



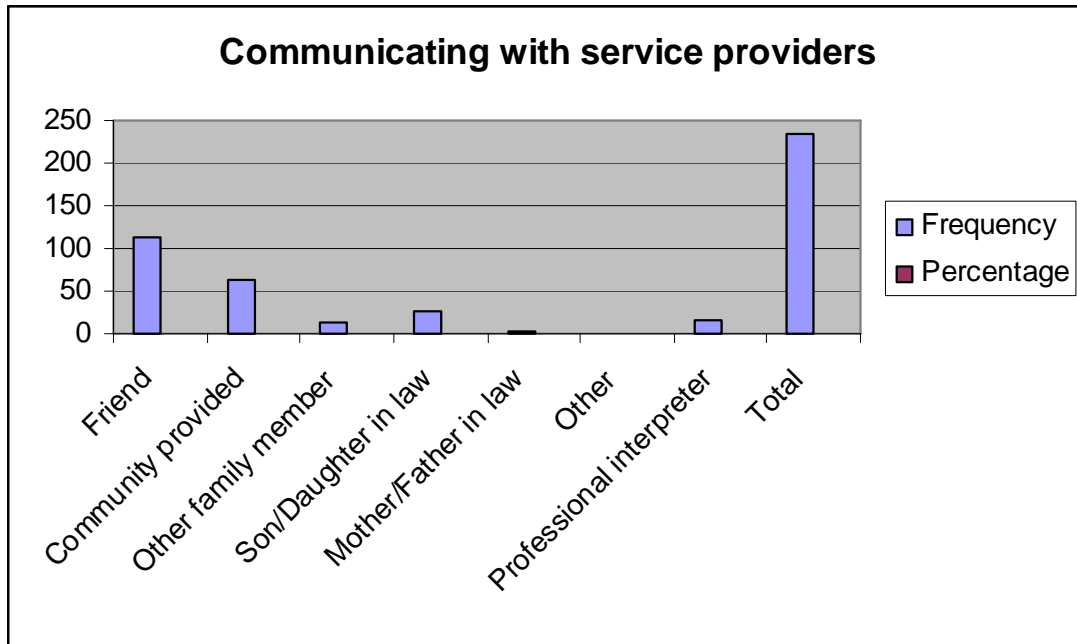
Nearly two third of respondents reported that languages problems included:

- Inability to communicate in English
- Lack of interpreter
- Reluctance of some service provider agencies to provide services to clients who did not speak English
- Unhelpful and impolite manner of administrative staff

Communicating with service providers

The majority of interviewees tried to use or would try to use some English to communicate with service providers although only 17% reported to be able to speak it fluently. But almost all of them reported that they experienced difficulties to understand service providers' officers. Therefore they needed interpreters to understand explanations they were given. Some respondents reported that even though they thought they were good at general English they still needed interpreters to better understand their interlocutors.

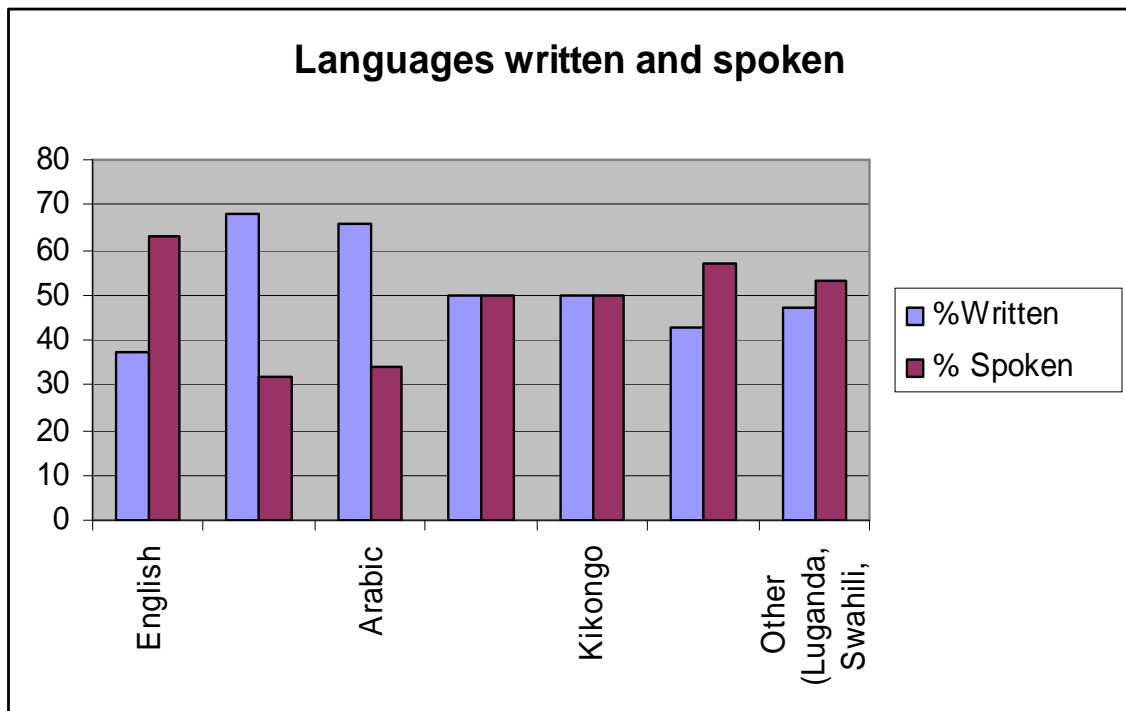
Provider	Frequency	Percentage
Friend	113	48%
Community provided	63	27%
Other family member	13	5%
Son/Daughter in law	27	11%
Mother/Father in law	3	1%
Other	0	0%
Professional interpreter	15	6%
Total	234	100%



The majority of respondents reported that the language barrier was even more complicated with GPs because, not only respondents did not understand properly what they were told due to their lack of English, but also because they did not, or they were not familiar with the medical jargon.

Languages written and spoken

Language	%Written	% Spoken
English	37	63
French	68	32
Arabic	66	34
Farsi	50	50
Kikongo	50	50
Creole	43	57
Other (Luganda, Swahili, Portuguese)	47	53



Most respondents spoke more than one language with varying stages of fluency. The major spoke French or Arabic.

Focus Group Discussions:

The focus group meetings tended to find out how refugees and asylum seekers received services in line with “Steps in Delivering Race Equality” (DRE) as outlined in the report. DRE’s programme of change is founded on three building blocks;

- **More appropriate and responsive services** - achieved through action to develop organisations and the workforce, to improve clinical services and to improve services for specific groups, such as older people, asylum seekers and refugees, and children.
- **Community engagement** - delivered through healthier communities and by action to engage communities in planning services, supported by 500 new Community Development Workers.
- **Better information** - from improved monitoring of ethnicity, better dissemination of information and good practice, and by improving knowledge about effective services. This includes a new yearly census of ethnicity of mental health patients. (Department of Health (2005); Delivering Race Equality in Mental Health)

Conclusion for the focus group meetings:

1. The overwhelming conclusion drawn was that none of the targets mentioned in the building blocks above are being met in delivering mental health services to refugees and asylum seekers in Lewisham.
2. The South London And Maudsley, which is mandated to deliver mental health services in the Lewisham Primary Care Trust area has only just been commissioned and it is going to be a while before there is an effective framework that can deliver better and more culturally appropriate, clinically effective and recovery orientated care for Black and minority ethnic communities, as well as demonstrate how the different initiatives will produce the improvements needed. (Annual Report 2004/05: South London and Maudsley NHS).
3. There are two under funded community based organisations in Lewisham who can form part of the delivery framework. Many different organisations will need to be involved in delivering the programme, reflecting the complex nature of mental health service development.
4. The research findings will also be used to inform other refugees communities and other voluntary organisations, and statutory organisations in order to plan their services more appropriately.
5. The findings from this research show that refugees and asylum seekers, whether newly arrived or settled have considerable difficulties in accessing mental health services. And these difficulties are exacerbated by their mobility, housing circumstances, immigration status, their cultural difference and the lack of the English language.
6. The research group meetings also concluded that 'analysis paralysis' was a problem amongst refugees and asylum seekers and that the information available seems to cause more confusion than help.

The focus group discussions reflected the findings and conclusions drawn from questionnaires:

Other issues that arose from group discussions:

1. 91% responded that they accessing services at main health centres was difficult for them and they preferred to seek the help of community organisations to access services. With a community service, there is time to talk to someone at length.
2. The conclusion we draw is that asylum seekers need more than just the few minutes allowed for at a GP practice. And that they needed a facility that include counselling as well as food, room to talk to other people and share experiences.
3. 97% commented that accessing a mental health service is preferable at the level of the community with experienced workers with community skills and who understood the world around refugees and asylum seekers.

Analysis and Discussion:

- i. The research revealed that there is a big gap in defining mental illness and all of them used just one word to describe the condition. The word often used can be translated as mild to severe mental illness or madness in the Western description of the condition.
- ii. When asked to comment on the many descriptions of mental illness such as depression, acute anxiety, suicidal tendencies, many could not relate these to mental illness.
- iii. When given the available literature and processes for accessing mental health services 70% of respondents found the information too complex to understand, too incomprehensible or withheld or out of date, and as a result they felt deprived of opportunities to take full advantage of services available.
- iv. The 90% of respondents reported that they had a genuine fear and anxiety about approaching people in mental health for fear of being sectioned under the Mental Health Act. This is because they felt that services providers often deliberately carried out wrong diagnoses.
- v. 48% of respondents reported that they knew some people who were Sectioned simply because of mental health need assessment based on what they believed to be inaccurate understanding of symptoms and behaviour.
- vi. Those who have experienced mental problems reported they believed that mental health forms and processes were deliberately made difficult to put refugees and asylum seekers off seeking these services
- vii. The research found that too often; the first contact started and finished at a counter or desk, and therefore, the experience was deeply unsatisfying for many refugees and asylum seekers who tried to seek professional assistance with regard to mental health. Their status was a big hindrance to accessing services or even just information.
- viii. 65% of respondents reported that, when seeking mental services, they felt that they were tossed about between professionals and therefore felt discouraged to continue seeking mental health assistance. And they thought people working in reception desks do not seem to understand or even appreciate their conditions.
- ix. The conditions that refugees and asylum seekers live in is the most serious blockage to accessing services. Most respondents reported that they were deliberately accommodated in deprived areas and humiliating conditions than the general public.
- x. The current arrangements in service provision also puts service beyond reach because providers do not try to reach out to refugees and asylum seekers or try to assess their mental health needs, or try to meet their needs and felt that mental health services were not designed for refugees and asylum seekers.
- xi. The research therefore draws conclusion that many conditions of mental illnesses recorded within refugees communities could have been dealt with the introduction of counselling and mentoring at community level with

- its mostly INFORMAL settings
- xii. In the whole Lewisham Primary Trust area, only three community organisations provided mental health services. And the Community Opportunities Services (COS) is beginning to tackle the gaps. The research concludes that there were very few and limited availability of BME practitioners who have the ability to understand the cultural sensitivity and diagnose correctly the ailments, within refugees' communities. **Annual Report 2004/05: South London and Maudsley NHS**
 - xiii. The research also concludes mental illnesses amongst refugees and asylum seekers communities were very closely linked to poverty and isolation as well as social exclusion and, most respondents reported that that there was a need to address issues of poverty and disadvantage affecting refugees and asylum seekers

Barriers and Gaps to Services

Because mental health services are a specialist service that can only be accessed through very bureaucratic referral systems, limited access to such health services by refugees and asylum seekers was generally attributed to barriers to social inclusion as a result of Section 55 of the Asylum Law that prevents access to welfare benefits while an asylum case is being processed. The general opinion expressed was that unless mental health service providers recognise and accept that there must be a change in the way policies are designed particularly on service delivery the plight of the refugees and asylum seekers would remain the same.

Some of the general issues identified, as barriers to inclusion are:

There is recognition by most of the respondents that information flow is a key determinant to picking up of mental health services and two things stick out:

Difference in defining mental health: There is a serious gap in the definition of mental health within the communities of refugees and asylum seekers represented in the research. Respondents defined mental health in a basic way. In terms of available definitions, respondents define mental health as the advanced stage of illness usually associated with being sectioned to a mental health institution. And in the UK, the definition of mental health is anything between a continuum of being normal to severe mental illness.

Difficulty in understanding available information: Most respondents concluded due to complex sources of information on mental health, access to information about services is inadequate, incomprehensible or withheld, people are deprived of opportunity to take a fuller advantage of services. Where there are local agencies available, they do not provide information, which are accessible therefore; communities are deprived of the knowledge of available services.

Discussion suggests three levels of difficulty in making use of available

information:

- First finding where information about mental health service was available and in what form. Second, in some cases little useful information was available and was sometimes out of date. Third, when documents, forms or posters were available, they are sometimes difficult to read, badly presented, and generally lacked clarity.
- There was a perception that mental health forms and processes were deliberately made difficult to put people off and little thought went into the content, presentation or appropriateness of information.
- But minority ethnic people also face additional problems, such as services that do not meet their particular needs or circumstances.
- **Front -Desk Problems.** First contact was often at a counter or desk, and the experience was found to be important and deeply unsatisfying for many Staffs who meet the mental health are sometimes not fully aware of procedures; did not always have full, accurate information; and sometimes, did not deal with people appropriately. Examples cited were Social Security offices and Housing Department.
- **Psychological barriers:** Often derive from low self-esteem, low morale and low assertiveness. Some of these trends cannot be seen in isolation but are part of consequences of Section 55, long-term neglect of BME issues on mental health, disappointment and disillusionment from continuous disadvantage and prejudice.
- **Stereotype and Prejudice:** A fixed and distorted generalisation made about all members of a particular group. Stereotyping and preconceptions are some of the serious hurdles, which have hindered access to services as well as their advancement.
- **Lack of support to community organisations:** Marginalisation of the role of community and voluntary sector organisations limit the link of some segment of the community to services as many members of the group are more at ease with voluntary and community sector organisations. Funders and regeneration partnerships need to recognise the value added by the Community and Voluntary sector by supporting and researching it properly to improve the quality and delivery of services.
- **Lack of proper accommodation:** Refugees and asylum seekers and other minority ethnic communities are relatively more likely to live in deprived areas than other people and they, therefore, experience all the problems, which affect every one in those areas.
- **Services are difficult to access:** Respondents asserted that health services in general do not always reach people from minority ethnic groups or meet their needs because they are not designed in a way that would reach specific minority ethnic groups and meet their needs.
- **Image problem for mental health authorities:** Respondents expressed genuine fear and anxiety about approaching people in mental health for fear of being Sectioned. In many cases such as asylum seekers, refugees and older people these feelings arise from the perceived stigma of having to seek for certain types of help. This is particularly true in relation to welfare benefits, mental health services and using the services of the police even when they are the victims of racial harassment, discrimination

- or other crimes.
- **Cultural Barriers:** Cultural inhibitions or unwillingness by some of those in need to come forward for help because of the stigma attached.
 - In other cases, evidence suggests that because services do not adequately meet the mental health needs of people from minority ethnic communities, members of the group lack confidence in mental health services.
 - Related to the above is the suspicious perception by prospective service users of service providers carrying out wrong diagnoses. This was mainly due to language and cultural factors.
 - Respondents claim that some people they knew were Sectioned because their assessments were sometimes based on inaccurate understanding of symptoms and behaviour, which are culturally rooted.
 - There is a lack of pre-illness care in the form of counselling and mentoring. A lot of the mental illnesses could have been prevented with the introduction of counselling and mentoring at the community level with its mostly INFORMAL settings. This is particularly true of the young people within the target group.
 - There is a limited availability of BME practitioners who have the ability to understand the cultural sensitivity and diagnose correctly the ailments of the members of the BME groups.
 - Many BME children, particularly new arrivals in the UK, are stereotypically dumped into failing schools, thereby reinforcing the perception of failure both for the children and the school.
 - Ethos of BME Organisations and the Perception of Mainstream Agencies
BME organisations cover the whole spectrum of social policy areas that affect the communities whose needs they seek to meet. They include health, social care, housing, employment, training and education. Many of the groups have strong emphasis on advice and advocacy, and have a holistic approach to service delivery, more by default than design. They also recognise the link between different service areas and their effect on the BME communities. However, they chase different funding streams to meet running costs and are heavily dependent on various funding policy and priorities. A large number of the organisations have to struggle to meet the demands placed on them by funders because of lack of resources. This is a key issue for most of them.
 - Most BME organisations are grass root community based organisations. They have established themselves over the years in response to the demands of BME communities and the absence of culturally sensitive services by mainstream providers. The organisations have a strong self-help ethos based on the values and the communities they serve.
 - The findings reveal that there are many barriers to involving BME organisations. Central to this is the failure of the local authority to engage BME organisations. The response from the authority has been the traditional gate keeping access to resources and power brokerage rather than facilitating both community empowerment and involvement. The implication of this approach to regeneration of the local area is the inability of various schemes to reflect the aspirations and concern of the BME communities in the design and delivery of services.

- The perception of statutory organisations about BME groups is negative. In situations where the voluntary and community sector groups are invited to participate in service delivery, BME organisations are perceived as too small and their capacity and organisational management as not sufficiently robust to be trusted with mental health funds.
- Whilst some mainstream organisations recognise the need to address issues of poverty and disadvantage affecting BME communities they are often unprepared to actively engage and trust BME groups with funds or offer other support. For example, Somali people are perpetually classified as refugees or asylum seekers and often referred to the Lewisham Refugee Network each time they request for assistance in accessing services. This is evidence of distinctive discrimination and stereotyping, which constitute barriers to services.
- Issues of viability and capacity to deliver are often raised by mainstream organisations as the reasons why it is difficult to involve BME organisations in the design and delivery of regeneration programmes.
- However, the issue of viability is not just a question of size but also an issue of effective delivery of services and managerial competence which some of the groups possess.
- Mainstream organisations often fail to understand the value-driven culture of many BME organisations.
- Mainstream agencies do not recognise their competencies in the design and delivery of services to hard to reach people in the community.
- There is a lack of knowledge of the actual needs of most groups, as BME organisations are not represented in the design of services. There are culturally sensitive issues which mental health organisations often ignore because they are perceived as not consistent with established code of practice the emphasis on Equal Opportunities policy notwithstanding.
- Effectively therefore, the clear picture of the BME community groups is that of a sector with limitless potentials and capabilities, but hugely under-utilised.
- The structure of the groups can be classified into four organisational strands. The knowledge of the communities possessed by the BME Voluntary organisations is a huge resource bank, which has not been tapped or utilised by the statutory providers of services.
- Community groups have been involved over a long period of time in the provision and delivery of services to hard to reach groups, albeit on a very small scale. It would seem therefore that the way forward is to find a modality for formalising the form and mode of their participation in the design and delivery of service.
- Indeed, there is a huge tool of development available and the hard choice is whether to insist on the cosmetic requirements of funding, or to dispense with such cosmetics in order to use a very natural and available instrument, which can be developed and modernised. That indeed is the choice before the statutory agencies.

Conclusion:

The management team of the Lewisham Day centre is happy to share these findings and hope that this research will encourage service providers, funders, and other relevant agencies to be more responsive to the needs of refugees and asylum seekers and centre's users and will be more supportive to the work of Lewisham Day Centre for Refugee and Asylum Seekers.

It is hoped that the findings of this research, and of the number of refugees and asylum seekers living in Lewisham and, their needs and experiences, can be useful to the Lewisham Day Centre, other voluntary organisations and the local authorities in:

- deciding what should be done to alleviate their needs
- applying for funding in order to meet their needs
- attracting volunteers or to help in kind
- raising awareness on issues affecting local refugees and asylum seekers

However it should be borne in mind that:

- Refugees communities or patterns of needs may change with time
- It can be difficult to keep track, or gather views from some refugees and asylum seekers
- Issues can be identified, described in different ways between different refugees communities and therefore, there should be different approaches while assessing the needs of different refugees groups
- There are some issues that some refugees and asylum seekers can be reluctant to recognise or talk about in public and therefore there is a need to encourage community initiatives as many refugees and asylum seekers are more comfortable to talk to their community members rather than to service providers' staffs
- Communication can sometimes be difficult because of the difference of level of understanding between refugees and asylum seekers and/or service users, especially with regard to mental health issues.
- The research concluded that 'analysis paralysis' was a problem amongst refugees and asylum seekers and that the information available seems to cause more confusion than help.

Recommendations:

With reference to tasks identified in *Delivering Race Equality*, there is a lot of work needs to be done. The DRE action plan was designed to achieve three key aims of:

- Equality of access
- Equality of experience
- Equality of outcomes

for BME mental health service-users.

On the basis of the findings of this study the following recommendations have been made in the following areas:

1. Low threshold preventative mental health services should be delivered via refugee community organisations that are easily accessed by refugees and asylum seekers.
2. Clear and simple information about the help that is available and how to access it is needed in community languages.
3. Greater availability and access to interpreters
4. More to be done to address the social exclusion of asylum seekers and refugees
5. There is a need for an advocacy role to support refugees and asylum seekers

Information provisions

- Produce a user-friendly leaflet about mental health services in the most spoken community language on mental health services available and procedures for accessing them and on specific issues for refugees and asylum seekers.
- A list of definitions of mental illnesses need to be readily available so that those affected can self assess or help other friends or family members if they see them experiences symptoms of mental illnesses.
- Update and supply these information materials continuously and as long as refugees and asylum seekers continue to come to the UK and as long as they are needed.
- Distribute these information materials to as many refugees and asylum seekers and users of refugee community organisations.
- Monitor and facilitate the dissemination of these information materials.
- Link with more relevant agencies and other community organisations in order to share information and experience as to how to better tackle mental health issues within refugees and asylum seekers communities.

Advocacy and interpreting

- Encourage community advocates and interpreters to use community languages.
- Collaborate with statutory departments and other service providers to facilitate interpreting and advocacy needs of services users, for example with social services.

Liaising with service providers and training for the community

- Conduct seminars on a wide range mental health issues as they affect refugees and asylum seekers.
- Provide regular mental health awareness training to community workers and volunteers

Resources

- Make more resources available for asylum seekers and refugees in order to provide more services in advocacy / interpreting and cultural counselling as well as information provision for refugees and asylum seekers.
- Make more resources available to mental health service providers and agencies that have clients such as refugees and asylum seekers who do not speak English.
- Helping the centres providing services become more efficient and more responsive to the needs of refugees and asylum seekers.
- Helping the Centres with the necessary resources to inform refugees and asylum seekers about mental health issues

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